FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032011

Facility Name: Norridge Healthcare & Rehab Centre

Address: 7001 W. Cullom Ave. (Number) Norridge (City) 60656 (Zip Code)

County: Cook

Telephone Number: (708) 457-0700 **Fax #** (708) 457-8852

IDPA ID Number: 36-3485852

Date of Initial License for Current Owners: 1-Jan-1987

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christopher Vicere **Telephone Number:** (773) 604-8112

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 30-Mar-2001 (Date)
(Type or Print Name) Christopher Vicere
(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	210	Skilled (SNF)	210	76,860	1
2		Skilled Pediatric (SNF/PED)			2
3	105	Intermediate (ICF)	105	38,430	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	315	TOTALS	315	115,290	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,334	11,814	8,268	33,416	8
9	SNF/PED					9
10	ICF	43,185	15,823	454	59,462	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	56,519	27,637	8,722	92,878	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.56%

D. How many bed-hold days during this year were paid by Public Aid? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1-Jan-1987

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1-Jan-1987 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 210 and days of care provided 6,860

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2000 Fiscal Year: 12/31/2000

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	365,778	55,966	20,753	442,497		442,497		442,497			1
2	Food Purchase		439,465		439,465	(21,521)	417,944	(1,226)	416,718			2
3	Housekeeping	336,491	98,601		435,092		435,092		435,092			3
4	Laundry	136,372	75,316		211,688		211,688		211,688			4
5	Heat and Other Utilities			219,000	219,000		219,000		219,000			5
6	Maintenance	76,293	71,261	75,648	223,202		223,202	4,547	227,749			6
7	Other (specify):*											7
8	**TOTAL General Services**	914,934	740,609	315,401	1,970,944	(21,521)	1,949,423	3,321	1,952,744			8
	B. Health Care and Programs											
9	Medical Director			19,500	19,500		19,500		19,500			9
10	Nursing and Medical Records	3,224,253	294,775	205,550	3,724,578		3,724,578		3,724,578			10
10a	Therapy		11,532	83,430	94,962		94,962		94,962			10a
11	Activities	123,406	25,433	5,225	154,064		154,064		154,064			11
12	Social Services	139,168		3,062	142,230		142,230		142,230			12
13	Nurse Aide Training			1,062	1,062		1,062		1,062			13
14	Program Transportation											14
15	Other (specify):* Dental Services			1,289	1,289		1,289		1,289			15
16	**TOTAL Health Care and Programs**	3,486,827	331,740	319,118	4,137,685		4,137,685		4,137,685			16
	C. General Administration											
17	Administrative	85,573		312,000	397,573		397,573	72,208	469,781			17
18	Directors Fees											18
19	Professional Services			49,246	49,246		49,246	5,653	54,899			19
20	Dues, Fees, Subscriptions & Promotions			89,755	89,755		89,755	(59,144)	30,611			20
21	Clerical & General Office Expenses	333,633	77,721	70,984	482,338		482,338	103,752	586,090			21
22	Employee Benefits & Payroll Taxes			692,701	692,701	21,521	714,222	21,203	735,425			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,743	10,743		10,743	6,150	16,893			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			71,855	71,855		71,855		71,855			26
27	Other (specify):*							17,680	17,680			27
28	**TOTAL General Administration**	419,206	77,721	1,297,284	1,794,211	21,521	1,815,732	167,502	1,983,234			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,820,967	1,150,070	1,931,803	7,902,840		7,902,840	170,823	8,073,663			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Norridge Healthcare & Rehab Centre #0032011 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			83,543	83,543		83,543	512,855	596,398			30
31	Amortization of Pre-Op. & Org.							10,811	10,811			31
32	Interest			81,692	81,692		81,692	212,315	294,007			32
33	Real Estate Taxes			448,965	448,965		448,965		448,965			33
34	Rent-Facility & Grounds			2,484,000	2,484,000		2,484,000	(2,484,000)				34
35	Rent-Equipment & Vehicles			12,623	12,623		12,623		12,623			35
36	Other (specify):*											36
37	**TOTAL Ownership**			3,110,823	3,110,823		3,110,823	(1,748,019)	1,362,804			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		147,763	93,092	240,855		240,855		240,855			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			172,936	172,936		172,936		172,936			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		147,763	266,028	413,791		413,791		413,791			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,820,967	1,297,833	5,308,654	11,427,454		11,427,454	(1,577,196)	9,850,258			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(7,937)	30		9
10	Interest and Other Investment Income	(246)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,226)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(450)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,906)	21		24
25	Fund Raising, Advertising and Promotional	(74,828)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,692)	20		28
29	Other-Attach Schedule Deferred Maintenance Costs	4,547	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (84,738)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,492,458)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,492,458)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,577,196)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Norridge Healthcare & Rehab Centre

ID# 0032011

Report Period Beginning: 1/1/2000

Ending: 12/31/2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintanance Costs	$ 4,547	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
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63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	4,547		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,226)	0	0	0	0	0	0	0	0	0	0	(1,226)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	4,547	0	0	0	0	0	0	0	0	0	0	4,547	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	3,321	0	0	0	0	0	0	0	0	0	0	3,321	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	21,556	50,652	0	0	0	0	0	0	0	0	72,208	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	5,653	0	0	0	0	0	0	0	0	0	5,653	19
20	Fees, Subscriptions & Promotions	(76,970)	3,004	14,822	0	0	0	0	0	0	0	0	(59,144)	20
21	Clerical & General Office Expenses	(2,906)	104,067	2,591	0	0	0	0	0	0	0	0	103,752	21
22	Employee Benefits & Payroll Taxes	0	6,550	14,653	0	0	0	0	0	0	0	0	21,203	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,589	4,561	0	0	0	0	0	0	0	0	6,150	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	17,680	0	0	0	0	0	0	0	0	0	17,680	27
28	**TOTAL General Administration**	(79,876)	160,099	87,279	0	0	0	0	0	0	0	0	167,502	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(76,555)	160,099	87,279	0	0	0	0	0	0	0	0	170,823	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Norridge Healthcare & Rehab Centre **#** 0032011 **Report Period Beginning:** 1/1/2000 **Ending:** 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(7,937)	407	520,385	0	0	0	0	0	0	0	0	512,855	30
31	Amortization of Pre-Op. & Org.	0	0	10,811	0	0	0	0	0	0	0	0	10,811	31
32	Interest	(246)	65,728	146,833	0	0	0	0	0	0	0	0	212,315	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(2,484,000)	0	0	0	0	0	0	0	0	(2,484,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(8,183)	66,135	(1,805,971)	0	0	0	0	0	0	0	0	(1,748,019)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(84,738)	226,234	(1,718,692)	0	0	0	0	0	0	0	0	(1,577,196)	45

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		17	Salary - Cynthia & Laurence	$	Lancaster, Ltd.	100.00%	$ 318,462	$ 318,462	1
2	V		27	P/R Taxes - Cynthia & Laurence		Lancaster, Ltd.	100.00%	8,894	8,894	2
3	V		17	Management Fee Income	312,000	Lancaster, Ltd.	100.00%		(312,000)	3
4	V		19	Professional Services		Lancaster, Ltd.	100.00%	5,653	5,653	4
5	V		21	Office Expenses		Lancaster, Ltd.	100.00%	6,500	6,500	5
6	V		22	Employee Benefits		Lancaster, Ltd.	100.00%	6,550	6,550	6
7	V		24	Education & Seminars		Lancaster, Ltd.	100.00%	1,589	1,589	7
8	V		17	Administrative Consultant		Lancaster, Ltd.	100.00%	15,094	15,094	8
9	V		32	Interest		Lancaster, Ltd.	100.00%	65,728	65,728	9
10	V		30	Depreciation		Lancaster, Ltd.	100.00%	407	407	10
11	V		21	Salaries - Clerical		Lancaster, Ltd.	100.00%	97,567	97,567	11
12	V		27	P/R Taxes - Clerical		Lancaster, Ltd.	100.00%	8,786	8,786	12
13	V		20	Advertising		Lancaster, Ltd.	100.00%	3,004	3,004	13
14	Total				$ 312,000			$ 538,234	$ * 226,234	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rental Income	$ 2,484,000	Norridge Associates	100.00%	$	$ (2,484,000)	15
16	V	30	Depreciation		Norridge Associates	100.00%	520,385	520,385	16
17	V	17	Administrative Consultant		Norridge Associates	100.00%	50,652	50,652	17
18	V	20	Advertising		Norridge Associates	100.00%	7,602	7,602	18
19	V	32	Interest		Norridge Associates	100.00%	146,833	146,833	19
20	V	20	Licenses & Fees		Norridge Associates	100.00%	25	25	20
21	V	31	Amortization Expense		Norridge Associates	100.00%	10,811	10,811	21
22	V	20	Contributions		Norridge Associates	100.00%	7,195	7,195	22
23	V	22	Holiday		Norridge Associates	100.00%	14,653	14,653	23
24	V	24	Seminars & Travel		Norridge Associates	100.00%	4,561	4,561	24
25	V	21	General Office expenses		Norridge Associates	100.00%	2,591	2,591	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,484,000			$ 765,308	$ * (1,718,692)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	Cynthia Chow	Officer	Administrative	50.00%	See Attached	25	38.46%	Lancaster	$ 138,462	17-7	1
2	Laurence Zung	Officer	Administrative	50.00%	See Attached	24	50.00%	Lancaster	180,000	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 318,462		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2000 Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lancaster, Ltd.
Street Address: 3520 W. Thorndale Ave.
City / State / Zip Code: Chicago, IL. 60659
Phone Number: (773) 539-8181
Fax Number: (773) 539-8133

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Cynthia Chow	Hours Worked	65	7	$ 360,000	$ 360,000	25	$ 138,462	1
2	27	Cynthia Chow	Hours Worked	65	7	10,054	0	25	3,867	2
3	17	Laurence Zung	Hours Worked	48	7	360,000	360,000	24	180,000	3
4	27	Laurence Zung	Hours Worked	48	7	10,054	0	24	5,027	4
5										5
6										6
7	19	Professional Services	Management Fees	1,455,000	7	26,361	0	312,000	5,653	7
8	21	Office Expenses	Management Fees	1,455,000	7	30,313	0	312,000	6,500	8
9	22	Employee Benefits	Management Fees	1,455,000	7	30,548	0	312,000	6,550	9
10	24	Education & Seminars	Management Fees	1,455,000	7	7,408	0	312,000	1,589	10
11	17	Administrative Consultant	Management Fees	1,455,000	7	70,392	0	312,000	15,094	11
12	32	Interest	Management Fees	1,455,000	7	306,522	0	312,000	65,728	12
13	30	Depreciation	Management Fees	1,455,000	7	1,898	0	312,000	407	13
14	21	Salaries - Clerical	Management Fees	1,455,000	7	454,998	454,998	312,000	97,567	14
15	27	P/R Taxes Clerical	Management Fees	1,455,000	7	40,971	0	312,000	8,786	15
16	20	Advertising	Management Fees	1,455,000	7	14,009	0	312,000	3,004	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,723,528	$ 1,174,998		$ 538,234	25

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Lincoln National Bank		X	Mortgage	$69,917.94	3/10/93	$ 4,875,000	$ 1,166,424	6/10/02	9.50%	$ 146,832	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Lancaster, Ltd.	X		Working Capital							81,692	6
7												7
8												8
9	TOTAL Facility Related				$69,917.94		$ 4,875,000	$ 1,166,424			$ 228,524	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,875,000	$ 1,166,424			$ 228,524	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	452,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	446,465	2
3. Under or (over) accrual (line 2 minus line 1).	$	(6,035)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	455,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	448,965	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	394,937	8
	1996	401,731	9
	1997	406,247	10
	1998	441,463	11
	1999	446,465	12

***Based on 1999 Actual Taxes ***

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 89,972 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 165,278
2. Number of Years Over Which it is Being Amortized: 15
3. Current Period Amortization: 10,811
4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Care Facility		1986	$ 650,000	1
2	Sect 754 basis adj.			126,788	2
3	TOTALS			$ 776,788	3

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	315		1986	1976	$ 9,204,000	$ 478,608	30	$ 478,608	$	$ 4,819,828	4
5					1,315,965	41,777	30	41,777		366,594	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	43,548	1,382	20	2,177	795	23,468	9
10	Various			1988	3,940	125	20	197	72	2,561	10
11	Various			1988	28,574	1,306	20	1,664	358	21,964	11
12	Various			1989	1,296	41	20	65	24	726	12
13	Various			1990	3,827	121	20	191	70	2,054	13
14	Various			1990	28,644	909	20	1,433	524	12,801	14
15	Various			1991	72,916	2,314	20	3,650	1,336	30,408	15
16	Various			1992	36,639	1,419	20	1,944	525	14,717	16
17	Various			1993	72,513	1,920	20	3,627	1,707	24,817	17
18	Various			1994	116,349	3,068	20	5,854	2,786	36,287	18
19	Various			1995	95,409	2,447	20	4,770	2,323	28,325	19
20	Boiler/Hot Water Heater Improvements			1996	9,417	241	20	471	230	2,355	20
21	Tuckpointing			1999	28,900	741	20	1,445	704	2,890	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 11,061,937	$ 536,419		$ 547,873	$ 11,454	$ 5,389,795	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 376,153	$ 55,099	$ 38,127	$ (16,972)	10	$ 214,131	37
38	Current Year Purchases	14,389	5,014	1,348	(3,666)	10	1,348	38
39	Fully Depreciated Assets	915,514	7,803	9,050	1,247		915,514	39
40								40
41	TOTALS	$ 1,306,056	$ 67,916	$ 48,525	$ (19,391)		$ 1,130,993	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 13,144,781	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 604,335	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 596,398	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (7,937)	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 6,520,788	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: *** N/A - Related Party Lease ***

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 12,623 Description: Minolta Copier @ $ 1,052/month
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 96

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 32

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies		481	581		1,062
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$ 481	$ 581	$	$ 1,062
10	SUM OF line 9, col. 1 and 2	(e)	$ 1,062			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ N/A

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	29
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	24
2. From other facilities (f)	
TOTAL TRAINED	53

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 39,509	$		$ 39,509	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			4,808			4,808	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			48,775			48,775	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				118,671		118,671	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): *Special Bed Rental	39-2					29,092		29,092	13
14	TOTAL			$		$ 93,092	$ 147,763		$ 240,855	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 **Report Period Beginning:** 1/1/2000 **Ending:** 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (37,068)	$ (15,557)	1
2	Cash-Patient Deposits	45,648	45,648	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,539,262	2,539,262	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	78,585	78,585	6
7	Other Prepaid Expenses	12,825	12,825	7
8	Accounts Receivable (owners or related parties)	22,705	732,816	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,661,957	$ 3,393,579	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		776,788	13
14	Buildings, at Historical Cost		10,519,965	14
15	Leasehold Improvements, at Historical Cost	541,971	541,971	15
16	Equipment, at Historical Cost	862,922	1,306,056	16
17	Accumulated Depreciation (book methods)	(883,737)	(8,535,477)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		162,166	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(151,362)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **Goodwill**	100,000	100,000	22
23	Other(specify): **Construction in Progress**	282,372	282,372	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 903,528	$ 5,002,479	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,565,485	$ 8,396,058	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 221,738	$ 221,738	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,174	5,174	28
29	Short-Term Notes Payable	1,168,706	1,018,706	29
30	Accrued Salaries Payable	445,776	445,776	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,623	11,623	31
32	Accrued Real Estate Taxes(Sch.IX-B)	455,000	455,000	32
33	Accrued Interest Payable	51,501	57,921	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,359,518	$ 2,215,938	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,166,425	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 1,166,425	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,359,518	$ 3,382,363	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,205,967	$ 5,013,695	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,565,485	$ 8,396,058	48

***(See instructions.)**

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 434,451	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 434,451	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	771,516	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 771,516	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,205,967	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		Total After Consolidation	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,093,487	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,093,487	6
	A. Additions (deductions):		
7	NET Income (Loss)	2,490,208	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,570,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 920,208	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,013,695	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,244,997	1
2	Discounts and Allowances for all Levels	(891,958)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,353,039	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	349,407	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 349,407	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	19,555	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	153,031	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,370	19
20	Radiology and X-Ray	13,690	20
21	Other Medical Services	292,392	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 492,038	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	246	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 246	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	**Vending Commissions**	4,240	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,240	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,198,970	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,970,944	31
32	Health Care	4,137,685	32
33	General Administration	1,794,211	33
	B. Capital Expense		
34	Ownership	3,110,823	34
	C. Ancillary Expense		
35	Special Cost Centers	240,855	35
36	Provider Participation Fee	172,936	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,427,454	40
41	**Income before Income Taxes (line 30 minus line 40)****	771,516	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 771,516	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. *Cash Basis Tax Payer**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,001	2,171	$ 71,192	$ 32.79	1
2	Assistant Director of Nursing	2,121	2,291	63,784	27.84	2
3	Registered Nurses	46,230	50,491	1,048,339	20.76	3
4	Licensed Practical Nurses	30,361	32,219	565,520	17.55	4
5	Nurse Aides & Orderlies	147,882	157,073	1,338,193	8.52	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,953	2,145	36,164	16.86	9
10	Activity Assistants	10,864	11,894	87,242	7.33	10
11	Social Service Workers	7,320	8,499	139,168	16.37	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	40,261	43,428	365,778	8.42	15
16	Dishwashers					16
17	Maintenance Workers	5,857	6,311	76,293	12.09	17
18	Housekeepers	35,378	37,855	336,491	8.89	18
19	Laundry	20,009	21,791	136,372	6.26	19
20	Administrator	1,996	2,211	67,538	30.55	20
21	Assistant Administrator	950	1,076	18,035	16.76	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	21,445	23,505	333,633	14.19	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	9,728	11,201	137,225	12.25	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	384,356	414,161	$ 4,820,967 *	$ 11.64	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	692	$ 20,753	1-3	35
36	Medical Director	485	19,500	9-3	36
37	Medical Records Consultant	101	3,679	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	504	7,560	10-3	39
40	Physical Therapy Consultant	2,384	83,430	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	110	5,225	11-3	44
45	Social Service Consultant	81	3,062	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	4,357	$ 143,209		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,159	$ 62,859	10-3	50
51	Licensed Practical Nurses	752	18,614	10-3	51
52	Nurse Aides	6,098	112,838	10-3	52
53	TOTAL (lines 50 - 52)	9,009	$ 194,311		53

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sandra Bernett	Administrator	N/A	$ 67,538
Jason Atkin	Asst. Administrator	N/A	18,035
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 85,573

B. Administrative - Other

Description	Amount
Management Fees - Lancaster, Ltd.	$ 312,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 312,000

C. Professional Services

Vendor/Payee	Type	Amount
Health Data Systems, Inc.	Data Processing	$ 11,179
Power Software	Data Processing	3,083
Health Management	Data Processing	836
Administar	Data Processing	240
Winston & Strawn	Legal	23,444
Panarese & Panarese	Legal	515
Esquire Deposition Services	Legal	1,034
Frost, Ruttenberg & Rothblatt	Accounting	1,450
Richard Peelo & Associates	Accounting	2,500
Personnel Planners, Inc.	Payroll Tax Consultant	1,665
Purchasing Plus	Purchasing Consultant	3,300
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 49,246

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 48,675
Unemployment Compensation Insurance	29,047
FICA Taxes	367,418
Employee Health Insurance	209,572
Employee Meals	21,521
Illinois Municipal Retirement Fund (IMRF)*	
Misc. Employee Benefits	19,339
Retirement Plan Contributions	15,586
Holiday Expenses	3,064
Norridge Assoc. Allocation	14,653
Lancaster Allocation	6,550
TOTAL (agree to Schedule V, line 22, col.8)	$ 735,425

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 500
Advertising: Employee Recruitment	19,814
Health Care Worker Background Check	1,092
(Indicate # of checks performed 91)	
Licenses & Fees	8,543
Promotional Advertising	58,719
Contributions	450
Dues & Subscriptions	637
Related Parties Allocation	17,826
**Less: Contributions	(450)
Less: Public Relations Expense	(17,801)
Non-allowable advertising	(57,027)
Yellow page advertising	(1,692)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 30,611

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,524
Seminar Expense	8,219
Norridge Assoc. Allocation	4,561
Lancaster Allocation	1,589
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 16,893

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Painting & Decorating	May-96	$ 10,664	3	$ 3,555	$ 3,555	$ 1,777	$	$	$	$	$	$
2	Painting & Decorating	Sep-96	13,428	3	4,476	4,476	2,238						
3	Painting & Decorating	Nov-96	5,922	3	1,974	1,974	987						
4	Painting & Decorating	Jul-97	3,238	3	540	1,079	1,079	540					
5	Painting & Decorating	Nov-97	2,814	3	469	938	938	469					
6	Painting & Decorating	Mar-98	4,660	3		777	1,553	1,553	777				
7	Painting & Decorating	May-98	3,318	3		553	1,106	1,106	553				
8	Painting & Decorating	Aug-99	2,834	3			472	945	945	472			
9	Painting & Decorating	Nov-99	1,966	3			328	655	655	328			
10	Painting & Decorating	Mar-2000	585	3			97	195	195	98			
11	Painting & Decorating	Oct-2000	266	3			45	88	88	45			
12	Painting & Decorating	Nov-2000	50	3			8	17	17	8			
13	Painting & Decorating	Dec-2000	180	3			30	60	60	30			
14	Painting & Decorating												
15													
16													
17													
18													
19													
20	TOTALS		$ 49,925		$ 11,014	$ 13,352	$ 10,658	$ 5,628	$ 3,290	$ 981	$	$	$

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **31,566** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **172,936**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **21,521** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.